CAPITAL CITY FRUIT EMPLOYEE WELFARE BENEFITS PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2016

ARTICLE 1
DEFINITIONS

"**Benefit Program**" means the individual welfare benefit plans offered through this Plan and listed on Exhibit A, attached hereto and incorporated herein by this reference.

"**Claimant**" means a Participant or a beneficiary of a Participant who has asserted a claim for benefits under the Plan.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**Company**" means Capital City Fruit Co. and its Related Employers, if any, or any successors thereto, who have adopted this Plan.

"**DCAP**" means the dependent care assistance program established by the Company for the benefit of its eligible employees. The DCAP is a Benefit Program under the Plan.

"**Effective Date**" means January 1, 2016.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, as amended.

"**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

"**Health FSA**" means the health flexible spending account program established by the Company for the benefit of its eligible employees. The Health FSA is a Benefit Program under the Plan.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**Mental Health Parity Legislation**" means the Mental Health Parity Act and the Mental Health Parity and Addiction and Equality Act, as amended.

"**Participant**" means any common-law employee of the Company who is eligible to participate in, and receive benefits under, one or more of the Benefit Programs and who has elected to participate in one or more Benefit Programs in accordance with the terms and conditions established for that Benefit Program.

"**PHI**" means protected health information that is created or received by a Benefit Program that constitutes a "group health plan" under HIPAA and that relates to the past, present, or future physical or mental health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of

health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. PHI includes information of persons living or deceased.

"**Plan**" means this Capital City Fruit Employee Welfare Benefits Plan.

"**Plan Administrator**" means the Company.

"**Plan Sponsor**" means the Company.

"**Program Materials**" means the insurance contracts, certificate of insurance booklets, benefits booklets, summary plan descriptions and other governing documents of the Benefit Programs which are attached hereto and incorporated herein by reference as attachments.

"Related Employer" means any employer affiliated with Capital City Fruit Co. that under Code § 414(b), (c), or (m) is treated as a single employer with Capital City Fruit Co. for purposes of Code § 125(g)(4).

"**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act, as amended.

ARTICLE 2
INTRODUCTION

2.1 Introduction

This is the plan document and summary plan description for the Capital City Fruit Employee Welfare Benefits Plan, a group of welfare benefit plans offered by Capital City Fruit Co. to its eligible employees. Each of the benefit plans in this plan document is referred to as a "Benefit Program" and is listed on Exhibit A, attached hereto and incorporated herein by this reference. Benefit Programs may change from year to year at the discretion of the Plan Sponsor. Participants should refer to the most current Exhibit A for a list of the current Benefit Programs comprising this Plan. Each of the Benefit Programs continues to be a separate and distinct plan filing its own Form 5500 if required and the benefits are combined herein solely for documentation purposes.

Each of the Benefit Programs is summarized in the Program Materials. The Program Materials (containing the insurance contracts, certificate of insurance booklets, summaries, and other governing documents of the Benefit Programs), together with this document, constitute the plan document and summary plan description required by ERISA. Even though included in this Plan, the DCAP is not subject to ERISA.

ARTICLE 3
PLAN BENEFITS

3.1 Benefits

The Plan consists of several different Benefit Programs outlined on Exhibit A. Some of the Benefit Programs are fully-insured benefits provided through insurance companies selected by the Plan Sponsor. As fully-insured benefits, the applicable insurance company is responsible for financing and administering the benefits for the Benefit Program. Exhibit A lists whether the Benefit Program is fully-insured or self-funded and lists the insurance companies through which the fully-insured Benefit Programs are offered. The specific details of each Benefit Program can be found in the applicable Program Materials. Participants may also receive a copy of these documents by contacting the Plan Administrator.

3.2 Contributions

The cost of the benefits provided through the Benefit Programs may be funded in part by Company contributions and in part by Participant contributions. Participant contributions may or may not be pre-taxed as determined by the Company. The Company will determine and periodically communicate the Participant's share of the cost of the benefits provided through each Benefit Program, and it may change that determination at any time. Nothing herein shall require the Company to make any contributions toward the cost of the benefits provided through the Benefit Programs. Whether the Company pays any portion of the benefits and the specific amount is determined by the Company in its sole discretion.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant contributions. Participant contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

3.3 Qualified Medical Child Support Orders

With respect to Benefit Programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO)(defined in ERISA § 609(a)). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and their beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

3.4 Non-Vested Benefits

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Participant or beneficiary except with respect to claims that have actually

been incurred by any such person that would otherwise be eligible for payment under the Plan, as it is in effect when the expense is incurred.

ARTICLE 4
ELIGIBILITY AND PARTICIPATION REQUIREMENTS

4.1 Eligibility and Participation

Only eligible employees who qualify as Participants may participate in the Plan. An eligible employee is any common-law employee of the Company who is eligible to participate in, and receive benefits under, one or more of the Benefit Programs based on eligibility criteria adopted by the Plan Sponsor from time to time. A summary of the eligibility criteria for the various Benefit Programs is attached as Exhibit C. An eligible employee qualifies as a Participant and may begin participating in the Plan upon his or her election to participate in a Benefit Program in accordance with the terms and conditions established for that Benefit Program. Certain Benefit Programs may require an annual election to enroll for coverage. For Benefit Programs that qualify as "group health plans" there may be circumstances that allow an eligible employee and his/her eligible spouse/dependents to enroll in the Benefit Program mid-year, such as marriage, birth or adoption, provided the Participant provides timely notice of the special enrollment event. Information about enrollment procedures, including when coverage begins and ends for the various Benefit Programs, is found in the Program Materials and policies maintained by the Plan Sponsor regarding employee eligibility for benefits.

Spouses and dependents of eligible employees are not entitled to participate in the Plan but may be beneficiaries of a Benefit Program in accordance with the terms of the applicable Benefit Program. Information regarding coverage of spouses and dependents is found in the Program Materials.

4.2 Circumstances That May Affect Coverage/Benefits

Coverage and benefits under the Plan will cease when the employee ceases to be an eligible employee or the Plan is terminated in accordance with Section 7.1. Coverage and benefits under a specific Benefit Program may also be terminated in other circumstances in accordance with the Program Materials. In most instances if a spouse or dependent is a beneficiary under a Benefit Program, their coverage under the Benefit Program will cease when the employee's participation in this Plan is terminated. The Program Materials also provide information regarding other circumstances that may result in a reduction, recovery (through subrogation or reimbursement) or denial of benefits.

Under certain circumstances coverage for an eligible Participant and his/her spouse and dependents under a Benefit Program that constitutes a "group health plan" may be extended under COBRA, FMLA, or USERRA. For example, if group health plan coverage for a Participant or his or her eligible spouse and dependents ceases

because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then the employee and his or her eligible spouse and dependents may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the Program Materials for any group health plan offered through this Plan. For more information regarding coordination with FMLA or USERRA, please see the applicable Program Materials and the Plan Sponsor's policies relating to FMLA and USERRA leave.

ARTICLE 5
CLAIMS BY PARTICIPANTS AND BENEFICIARIES

A claim is a request for a Plan benefit. Participants participating in the Plan and their spouses and dependents receiving benefits through a Benefit Program have the right under ERISA (if applicable) and the Plan to file a written claim for benefits under the Plan. The manner and form for submitting claims for benefits is outlined in the Program Materials for the applicable Benefit Program.

5.1 Claims for Benefits Under Fully-Insured Benefit Programs

To obtain benefits under a fully-insured Benefit Program, the Claimant must follow the claims procedures under the applicable Program Materials which may require the Claimant to complete, sign and submit a written claim on the insurer's form. For purposes of determining the amount of, and entitlement to benefits under the Benefit Programs, the respective insurer is the named fiduciary with full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Benefit Program.

The insurance company will decide a Claimant's claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent advice, including medical advice, and to require such other evidence as it deems necessary in order to decide the claim. If the insurance company denies a claim in whole or in part, the Claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied in whole or in part the Claimant will be provided with written notice of the denial. A Claimant may appeal a denial in accordance with the appeal procedures outlined in the Program Materials for the applicable Benefit Program. If the Claimant does not appeal on time, the Claimant loses his/her right to file suit in a state or federal court, because he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). The Program Materials provide more information about how a Claimant files a claim and details regarding the applicable claims procedures for each Benefit Program.

5.2 Claims for Benefits Under Self-Funded Benefit Programs

To obtain benefits under a self-funded Benefit Program, the Claimant must follow the claims procedures under the applicable Program Materials which may require the Claimant to complete, sign and submit a written claim on the Company's forms. For purposes of determining the amount of, and entitlement to benefits under the Benefit Programs, the Company is the named fiduciary with full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Benefit Program. In some instances the Company may contract with an outside entity to assist in administering the self-funded Benefit Programs.

The Company, or other entity contracted by the Company to assist it in making claim decisions, will decide a Claimant's claim in accordance with its reasonable claims procedures, as required by ERISA to the extent ERISA is applicable (Note, ERISA is not applicable to the DCAP). The Company has the right to secure independent advice, including medical advice, and to require such other evidence as it deems necessary in order to decide the claim. If the Company denies a claim in whole or in part, the Claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied in whole or in part the Claimant will be provided with written notice of the denial. A Claimant may appeal a denial in accordance with the appeal procedures outlined in the Program Materials for the applicable Benefit Program. If the Claimant does not appeal on time, the Claimant loses his/her right to file suit in a state or federal court, because he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). The Program Materials provide more information about how a Claimant files a claim and details regarding the applicable claims procedures for each Benefit Program.

ARTICLE 6
FUNDING & PLAN ADMINISTRATION

6.1 Funding

Some of the Benefit Programs offered under this Plan are fully-insured meaning the applicable insurance company is responsible for financing and administering the benefits under the applicable Benefit Program. Some of the Benefit Programs are self-funded meaning benefits are paid by the Company. Exhibit A notes whether a benefit is fully-insured or self-funded. Premiums for Participants and their eligible beneficiaries may be paid by Company and/or Participant contributions as determined by the Company in its sole discretion. The Plan Administrator provides a schedule of the applicable premiums and required Participant contributions during the initial and subsequent open enrollment periods and on request.

6.2 Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in

accordance with its terms, for the exclusive benefit of Participants. The administrative duties of the Plan Administrator may include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities. With respect to self-funded benefits, the Plan Administrator may contract with an outside entity to assist it in administering the Benefit Program.

With respect to those Benefit Programs offered under the Plan that are fully-insured, the insurance companies offering benefits under the Benefit Programs are responsible for (a) determining eligibility for and the amount of any benefits payable under their respective Benefit Programs; and (b) prescribing claims procedures to be followed and the claims forms to be used by employees and beneficiaries pursuant to their respective Benefit Programs. The insurance companies, not the Company, are responsible for paying claims with respect to these fully-insured Benefit Programs.

6.3 Discretionary Authority of Plan Administrator

The Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including any Benefit Programs), and to determine all questions arising in connection with the administration, interpretation and application of the Plan (including any Benefit Programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion, and further, constitutes agreement to the limited standard and scope of review described in this section.

6.4 Costs of Plan Administration

The Company will bear its incidental costs of administering the Plan.

6.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or failure to act except for its own willful misconduct or willful breach of this Plan.

6.6 Indemnification

The Plan Administrator shall be indemnified and held harmless by the Plan against and from any and all losses, costs, liability or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this section shall not be applicable if the loss, cost, liability or expense is due to the Plan Administrator's gross negligence or willful misconduct.

6.7 Bonding

Unless required by ERISA or other applicable federal or state law, the Plan Administrator shall not be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

ARTICLE 7
AMENDMENT OR TERMINATION OF THE PLAN

7.1 Amendment or Termination

The Company as Plan Sponsor has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by any individual who has been given the authority by the Company's Board of Directors to amend or terminate the Plan. The Company's Board of Directors has authorized the Human Resources Manager to sign insurance contracts and make administrative amendments or amendments required by law and to update Exhibits A and B as needed based on changes in the Benefit Programs or information outlined therein. An amendment or termination of this Plan shall apply to a Related Employer who has adopted this Plan if subsequently adopted by the Related Employer.

ARTICLE 8
GENERAL INFORMATION ABOUT THE PLAN

8.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

8.2 COBRA

A federal law, known as COBRA, requires that Participants and eligible beneficiaries be given an opportunity to temporarily continue participation in the Plan with respect to a Benefit Program that qualifies as a "group health plan" if a Participant experiences a "qualifying event." "Qualifying events" include a Participant's termination of employment (other than for gross misconduct), reduction of hours, death, divorce or legal separation, entitlement to Medicare or a dependent ceasing to meet the definition of "dependent" under the group health plan. For qualifying events other than a change in employment status, it is the Participant's obligation to inform the Plan Administrator of its occurrence within 60 days of the occurrence. The Plan Administrator has the legal obligation to furnish the Participant and his/her beneficiaries eligible for COBRA with an election notice detailing how the Participant and/or beneficiaries may continue coverage under the group health plan and the cost of continuation coverage. The right of a Participant or beneficiary to continue coverage under a group health plan pursuant to COBRA is conditioned on the Participant or beneficiary timely electing the coverage and paying the cost of the coverage. COBRA coverage can last for up to 18 months and in certain situations may be extended for up to 29 or 36 months. The Program Materials for Benefit Programs qualifying as group health plans subject to COBRA provide detailed information regarding qualifying events, premiums and premium due dates, notice and election requirements and duration of coverage.

8.3 Military Leave

In accordance with USERRA, Participants performing military duty of more than 30 days may elect to continue coverage under a Benefit Program that qualifies as a health plan subject to USERRA for up to 24 months; however, they may be required to pay *up to* 102 percent of the full premium. For military service of less than 31 days, the Participant will continue to be eligible for the group health plan coverage as if the Participant had remained employed. More information regarding coverage during military leave can be found in the Program Materials of the Benefit Programs qualifying as health plans subject to USERRA and the Plan's Sponsor's policies.

8.4 Family & Medical Leave

To the extent FMLA is applicable to the Company, the Plan will comply with FMLA and regulations promulgated thereunder. During FMLA leave taken by a Participant, a Benefit Program that is considered group health plan coverage will continue on the same conditions as coverage would have been provided if the Participant had been continuously employed during the entire leave period. Group health plan

coverage will cease if the Participant chooses to drop coverage during FMLA leave, the Participant does not timely pay his/her share of the applicable premium, or the Participant does not return to work when the FMLA leave ends. If group health plan coverage terminates during the FMLA leave, coverage will be reinstated if the Participant returns to work in accordance with the terms of the FMLA.

Participants may have certain rights relating to continuation of other non-group health plan benefits offered under this Plan during FMLA leave. A Participant's FMLA rights are discussed in detail in the Company's FMLA policies and employee notices.

8.5 HIPAA Privacy/Security Protections

The Plan Sponsor shall have access to PHI only as permitted under this Plan or as otherwise required or permitted by HIPAA. The Plan (or Plan Administrator) may disclose to the Plan Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan. The Plan (or Plan Administrator) may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan. "Summary Health Information" means information summarizing the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a health plan; and from which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

The Plan may also disclose PHI to the Plan Sponsor as allowed by HIPAA for plan administration purposes which includes administrative functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include employment-related functions or functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Prior to disclosing PHI to Plan Sponsor for administrative purposes, Plan Sponsor must agree that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;

- Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524;

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR § 504(f)(2)(iii), is satisfied;

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic PHI it maintains, receives or transmits; and

- Only individuals who have been designated as needing access to PHI to perform plan administration functions will be authorized to have access to such PHI.

Prior to disclosing PHI to Plan Sponsor pursuant to this Section 8.8, Plan shall receive a written certification from the Plan Sponsor that the Plan Sponsor agrees to the conditions of disclosure set forth in this Section 8.8.

8.6 Compliance with Applicable Laws

The Plan will comply with all applicable federal laws and state laws whose applicability to the Plan is not preempted by ERISA. The Plan combines certain fully-insured and self-funded benefits for documentation and reporting purposes only. Nothing herein shall impact the application of ERISA preemption doctrine to the Benefit Programs.

8.7 Program Materials Control

Benefits are provided under the Plan pursuant to an insurance contract or other documents adopted by the Company. If the terms of this plan document and SPD conflict with the terms of such insurance contract or other Program Materials for the specific Benefit Program at issue, then the terms of the insurance contract or Program Materials will control for that Benefit Program rather than this document, unless otherwise required by law.

8.8 Summary Plan Description

This Plan document and the Program Materials shall also serve as the summary plan description for the Plan and each Benefit Program to the extent required by ERISA § 102.

8.9 Additional Plan Information

Important information regarding the Plan, the Plan Administrator, the Plan Sponsor and fiduciaries is listed on Exhibit B, attached hereto and incorporated herein by this reference.

8.10 Statement of ERISA Rights

This Plan is governed by ERISA with the exception of the DCAP. Participants have certain rights under ERISA which are outlined in detail in Exhibit C, attached hereto and incorporated herein by this reference.

8.11 Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The

Company as the Plan Sponsor shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

8.12 Waiver and Estoppel

No term, condition or provision of this Plan shall be deemed to be waived and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No which written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Participant or beneficiary shall be entitled to rely on the waiver for any purpose.

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Exhibits & Attachments:

Exhibit A: Fully-Insured & Self Funded Benefits & Insurance Company Information

Exhibit B: Information regarding the Plan, Plan Sponsor & Plan Administrator

Exhibit C: Eligibility Information

Exhibit D: Participant Notice of ERISA Rights

Attachment # 1: Short Term Disability Program Materials

Attachment # 2: Dental Benefits Program Materials

Attachment #3: Health FSA Program Materials

Attachment # 4: DCAP Program Materials

Attachment # 5: Cigna Group Life Insurance Program Materials

Attachment # 6 5 Star Group Term Life & AD&D Insurance Program Materials

Attachment # 7: Cigna Group AD&D Program Materials

Attachment # 8: Voluntary Life Insurance Program Materials

Attachment # 9: Voluntary LTD Program Materials

IN WITNESS WHEREOF, Capital City Fruit Board of Directors adopted this Plan on_____, effective as of January 1, 2016.

CAPITAL CITY FRUIT

By: _____

Its: _____

Witness Signature: _____

Exhibit A
Benefit Program Information
As of January 1, 2016

1. Capital City Fruit Short Term Disability Plan

Fully Insured Through:
Colonial Life
5550 Wild Rose Lane, Suite 400
Windsor Heights, Iowa 50266
PH 515-331-6636

2. Capital City Fruit Dental Plan

Fully Insured Through:
Delta Dental of Iowa
9000 Northpark Drive
Johnston, IA 50131
1-877-423-3582

3. Capital City Fruit Health Flexible Spending Arrangement

Self-Funded & Administered By:
Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211

Administrative Assistance From: Total Administrative Services Corporation
2302 International Lane
Madison, WI 53704-3140

4. Capital City Fruit DCAP Arrangement

Self-Funded & Administered By:
Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211

Administrative Assistance From: Total Administrative Services Corporation
2302 International Lane
Madison, WI 53704-3140

5. Capital City Fruit Cigna Group Life Insurance Plan

Fully Insured Through:
Cigna Group Insurance
7400 W. 110th Street, Suite 400
Overland Park, KS 66210
913-323-2692

6. Capital City Fruit 5 Star Group Life Insurance & AD&D Plan

Fully Insured Through:
5 Star
10600 S. Penn Ste 16 PMB 174
Oklahoma City, OK 73170
PH # 405-691-8429

7. Capital City Fruit Cigna Group AD&D Plan

Fully Insured Through:
Cigna Group Insurance
7400 W. 110th Street, Suite 400
Overland Park, KS 66210
913-323-2692

8. Capital City Fruit Voluntary Life Insurance Plan

Fully Insured Through:
Cigna Group Insurance
7400 W. 110th Street, Suite 400
Overland Park, KS 66210
913-323-2692

9. Capital City Fruit Voluntary Long Term Disability Plan

Fully Insured Through:
Cigna Group Insurance
7400 W. 110th Street, Suite 400
Overland Park, KS 66210
913-323-2692

Exhibit B

Information Regarding the Plan Administrator & Plan Sponsor

Plan Name

Capital City Fruit Employee Welfare Benefits Plan

Type of Plan

Welfare plan providing a variety of welfare benefits to eligible employees through fully-insured and self-funded programs.

Plan Year

The Plan year is January 1st - December 31st.

Plan Number

The Plan numbers for the various benefits are as follows:
CAPITAL CITY FRUIT EMPLOYEE WELFARE BENEFITS PLAN
Plan Number 509

Effective Date

The effective date of this wrap plan is January 1, 2016; however, the effective dates of the various benefits offered under the plan vary.

Funding Medium and Type of Plan Administration

Some of the benefits offered under this Plan are fully-insured and others are self-funded as noted in Exhibit A. Premiums may be funded in part by employer and employee contributions. While the Plan is administered by the Plan Administrator, for fully-insured benefits the insurance carrier for the applicable Benefit Program is responsible for financing and administering the Benefit Program.

Plan Sponsor

Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211
515-981-5111

Plan Sponsor's Employer Identification Number

42-0981294

Related Employers Who Have Adopted the Plan

Plan Administrator

Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211
515-981-5111

Named Fiduciary

Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211
515-981-5111

For Benefit Claims for Fully Insured Benefit Programs, the Named Fiduciary is the Insurer listed on Exhibit A.

Agent for Service of Legal Process

Chief Operations Officer
Capital City Fruit Co.
1850 Colonial Parkway
Norwalk, IA 50211
515-981-5111

Service for legal process may also be made on the Plan Administrator.

The specific individual at Capital City Fruit that individuals with questions relating to the Plan or Benefit Program should contact is the Human Resources Manager.

Exhibit C

ELIGIBILITY INFORMATION

1.Capital City Fruit Short Term Disability Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

2.Capital City Fruit Dental Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

3.Capital City Fruit Health Flexible Spending Arrangement - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

4.Capital City Fruit DCAP Arrangement – Eligible employees of the corresponding plan must have a qualifying event (see Section 8.2)

5.Capital City Fruit Cigna Group Life Insurance Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

6.Capital City Fruit 5 Star Group Life Insurance & AD&D Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

7.Capital City Fruit Cigna Group AD&D Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

8.Capital City Fruit Voluntary Life Insurance Plan - Eligible employees are fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date. Non-exempt employees are eligible the first of the month after 60 days from their hire date.

9.Capital City Fruit Voluntary Long Term Disability Plan - Eligible employees are exempt fulltime employees working 30 hours or more per week. Exempt employees are eligible the first of the month after their hire date.

Exhibit D

Statement of ERISA Rights

Your Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Capital City Fruit, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the applicable SPD or insurance booklet and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require Capital City Fruit, as Plan Administrator, to provide the materials and pay up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact Capital City Fruit's Human Resources Manager. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.